MASSACHUSETTS

Michael T. Caljouw, Senior Director
Public, Government, and Regulatory Affairs

May 27, 2010

David Morales, Commissioner
Division of Health Care Finance and Policy
2 Boylston Street, 5th floor
Boston, MA 02116

RE: 114.5 CMR 21.00, Health Care Claims Data Submission

Dear Commissioner Morales:

I am writing on behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA) to provide you with supplemental comments regarding the Division of Health Care Finance and Policy's (Division) above-referenced proposed regulations establishing an All Payer Claims Database. The following comments supplement our previously submitted testimony on the regulations by providing information relating to the specific data elements upon which we requested clarification.

In addition to the need for further definition and explanation on the below listed set of data elements, many other requested data elements are not currently in our data warehouse. If helpful, we would be happy to provide you with these specific data element numbers. Obtaining this information in the form requested by the Division will require resources and time. While it is not clear how much time will be needed to comply with the data request, the fact that additional clarification is necessary and the amount of data that is not even currently in our data warehouse makes the initial due date of October 15, 2010 very problematic.

With the ever changing landscape, we suggest that the data and file specifications be provided for in administrative bulletin rather than an appendix to the regulations. The administrative bulletin format will provide for more flexibility in the future for any changes in the specifications. Additionally, this will allow more time for the Division and carriers to work through the numerous data element questions and technical design issues.

Below we list the data files and specific element numbers that need additional clarification. Upon further review and discussion with the Division and other data submitters, it is possible that other elements may need clarification as well. Also, for some of the listed data elements, we have questions relating to encryption and security procedures since this type of information is not provided in the regulations or appendices.

Eligibility File – ME008, ME009, ME011, ME015, ME017, ME030, ME031, ME032, ME037, ME041, ME042, ME043, ME044, ME048, ME054, ME055, ME056, ME057, ME058, ME060, ME071, ME072, ME073, ME075, ME076, ME077, ME080, ME081, ME082.

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Medical Claims – MC068, MC100, MC101, MC102, MC103, MC104, MC105, MC106, MC122, MC126, MC127, MC128. MC129.

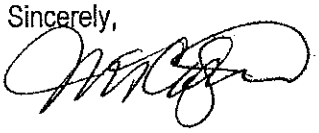
Pharmacy Claims – PC049, PC059, PC061, PC062, PC064, PC071, PC073, PC074.

Product File – PR003, PR010, PR011, PR019, PR020, PR021, PR022, PR023, PR024, PR025, PR026, PR027, PR028, PR029. PR030, PR031, PR034.

Provider File – PV003, PV006, PV013, PV014, PV015, PV016, PV018, PV019, PV020, PV021, PV022, PV023, PV024, PV025, PV026, PV027, PV028, PV029, PV030, PV032, PV033, PV034, PV035, PV037, PV038, PV039, PV045, PV046, PV051, PV056, PV058. PV060, PV062, PV063

Please do not hesitate to contact me with any questions you may have. We are more than happy to meet with the Division to review the data and file specifications in detail. Since other carriers may have similar questions, we would again suggest that the Division schedule a series of meetings with data managers from the various entities that will be submitting data to work through these technical issues. Thank you for your thoughtful consideration of these important issues.

Sincerely,



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Michael T. Caljouw, Senior Director
Public, Government, and Regulatory Affairs

May 17, 2010

David Morales, Commissioner
Division of Health Care Finance and Policy
2 Boylston Street, 5th floor
Boston, MA 02116

RE: 114.5 CMR 21.00, Health Care Claims Data Submission
114.5 CMR 22.00, Health Care Claims Data Release

Dear Commissioner Morales:

I am writing on behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA) to provide you with our comments regarding the Division of Health Care Finance and Policy's (Division) above-referenced proposed regulations establishing an All Payer Claims Database. While we support the Division's goal of reporting state-wide information on the cost and quality of health care for Massachusetts residents using a robust dataset necessary to provide detailed information for consumers, we have very serious concerns about the breadth of the new data being requested, the security of that data, and the need for a much more robust interactive process to address some of the technical design flaws. It is also important to note that the proposed regulations would result in added administrative cost for consumers and business that would be necessary to comply with these regulations.

BCBSMA recognizes that this form of cost and quality transparency – particularly with all-payer metrics behind it – is an important and potentially powerful lever for achieving the Division's overarching goals. This information will also be invaluable when considering potential payment reform models.

It is imperative that the Division work with other state agencies to ensure that the database created in these proposed regulations leads to administrative simplification and efficiencies through a more streamlined approach. In the future, other agencies must look to the Division's database, rather than request overlapping and duplicative data and reports on their own, or else the state would only be adding administrative burdens for health plans. For example, required current data submissions to the Quality and Cost Council, in many ways identical to data being requested from the Division, must be repealed prior to these regulations taking effect. We are not aware of any such requirement or agreement that other agencies look to the Division's database rather than submit additional data requests to the health plans.

Below, we provide detailed comments and suggestions on the proposed methodology. First, however, we strongly urge you to consider an alternative method for the collection of data. This alternative data

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collection strategy would allow the Division to report the full range of quality and cost information that it is considering, but with much greater security around the privacy of the data at substantially lower cost and in a substantially faster timeframe than if the raw claims data was collected.

This alternative method for obtaining and reporting the cost and quality data is based on a model used both nationally and locally by organizations charged with reporting health care performance data – for example, the National Committee for Quality Assurance (NCQA) and the Massachusetts Health Quality Partners (MHQP). Neither of these organizations takes in data at the claims-level, but rather hold health plans responsible for aggregating the data for reporting purposes. In the case of NCQA, the plans are responsible for taking all claims data to generate rates of various care processes (e.g. mammography screening or immunization rates) using highly prescribed methods that ensure that all carriers report in the same manner. This approach saves enormous expense in that NCQA is not required to take in the millions of raw claims required to generate the measures, but rather, it takes in the measures themselves. There are audit processes in place to support the validity of the measure results.

The same model would work with cost data. For every health care service, plans could provide information at the provider level indicating the cost or range of cost if it varies depending on product. This alternative approach, if the Division chooses to pursue it, would address some of the concerns around listing specific rates carriers pay to providers leading to a race to the top. While BCBSMA supports increased transparency, the proper context must be given. It would be unfortunate if increased transparency of provider payments for specific procedures increased the overall cost of health care based on a comparison to what reimbursement rates others receive. This aggregated data approach is increasingly recognized as both less expensive and less risky from a privacy perspective than the creation of large multi-payer multi-provider data repositories.

Moving to our comments on the proposed regulations, BCBSMA is very concerned that having one huge repository with protected health information (PHI) for every individual in the state greatly increases the risk of a security breach. Additional steps must be taken to ensure the security of this data. PHI information must be encrypted in the same way it currently is for data shared with the Division for the use by the Health Care Quality and Cost Council (QCC). Additionally, we would hope additional security measures are taken considering the sensitivity and breadth of this information. It is not clear from the regulations whether the new information not currently provided to the QCC will be encrypted and if so, by what means.

The encryption method is extremely important for many of the new elements being requested. Currently for the QCC, member social security numbers are encrypted. However, the data and file specifications for this All Payer Claims Database request not only member social security numbers, but provider information as well, including tax identification numbers. Additionally, in the enrollment extract, the Division requests account names and group names. This employer group information is not currently provided to the QCC. BCBSMA is not comfortable providing this sensitive information without additional information on the Division's encryption approach and process.

We would anticipate that any and all disclosures of data by health plans to the Division through its Data Management vendor comply with Federal HIPAA privacy and security regulations as well as all state confidentiality and privacy protection requirements. We anticipate that an appropriate "Business Associate" confidentiality agreement will be executed by the parties to ensure the security of any data transmission and storage with provisions that include the privacy of individually identifiable health information, that the limits of use of the information will be clearly defined. Similarly, we would expect that

business sensitive information will not be inappropriately used or disclosed by either the Division or the Data Management vendor. We strongly urge the Division to agree to undergo a series of security assessments and testing to understand the data transfer process and ensure the security of our members' data, prior to the actual implementation date.

It would be helpful to have clarification of the confidentiality provisions, especially as it relates to proprietary information. Specifically, we are worried about information requested in the Private Health Care Plan Information requested in 114.5 CMR 21.03(2). We believe that data relating to actuarial assumptions underlying premiums, medical and administrative expenses, and provider payment methods and levels should be considered and treated as proprietary information and not be released. The Division should ensure these proprietary data elements do not qualify as public records *and* the Division should ensure that the proprietary data elements are kept confidential and used only for appropriate research.

In this same section, 21.03(2), Private Health Care Plain Information, the information being requested is very similar to information provided to the Division of Insurance in premium rate filings. BCBSMA would recommend the Division use the Division of Insurance's regulations (211 CMR 43.00, Health Maintenance Organizations) as a guide to this request, especially as it relates to plan premiums, actuarial assumptions, and medical and administrative expenses. As currently written, the request is duplicative and burdensome on health plans.

It is not clear from the definition sections (114.5 CMR 21.02 and 22.02) if Health Care Payer ("Payer") applies to payers licensed in Massachusetts or all payers whose members receive care in Massachusetts. Given the close proximity of services in the New England area, there are many out-of-state payers whose members receive care in Massachusetts. Under the regulations, if information for all services in Massachusetts is required, it is likely that a claim will be available, but the member eligibility information would not be available because they are not members of BCBSMA. Clarification on the scope of this definition would be beneficial.

BCBSMA has numerous technical comments on very specific requested data elements and data design flaws. Rather than provide this level of detail through the hearing process, we encourage the Division to schedule a series of meetings with data managers from the various entities that will be submitting data to work through these technical issues. In this way, the Division and those submitting the data can all benefit from an interactive process and ensure that all are operating from the same understanding.

Regarding the Health Care Data request (21.03(4), Medical Claims, Member Eligibility, Pharmacy Claims, Dental Claims) section, the regulations currently require payers to submit this information on or before October 15, 2010 and thereafter on the 15th of each month. As mentioned above, there are a multitude of technical issues that still need to be resolved and further work to make sure the data itself is usable. Once we have clarity around the specific data we would need to produce, it will take us considerable time to produce and format per the Division's file specifications. We strongly recommend that the Division delay implementation of this section. A comprehensive data meeting between the Division and all plans is necessary to resolve a myriad of issues around the specific field ambiguities. Similar meetings took place when the QCC submission was being developed and it was invaluable to get questions answered in a uniform way and to provide the same information to all submitting plans. We cannot fully estimate the time or resources necessary until we understand all of the Division's requests, but an October 15 effective is clearly problematic.

For the Health Care Claims Data Release regulations (114.5 CMR 22.00), BCBSMA suggests that the enforcement provisions be increased. If an approved applicant fails to comply with the rules, there is little in terms of penalties in the present draft other than terminating current access and denying future access. We would recommend that the Division, upon notification of a violation of any of an applicant's terms, be required to report the incident to the Massachusetts Attorney General's Office for investigation and appropriate sanction.

While BCBSMA supports increased transparency and the Division's efforts, this new system will mandate added costs and expenses on our business operations. The requests set out in these regulations are considerably different than what is currently provided to the QCC. The additional changes and information requests will require significant resources including increased infrastructure and employees. Many of the data elements are not even currently available for our own internal access. In this economic climate, this increased cost is a concern for us and our customers. Steps to allow greater flexibility on the timing of reporting should be adopted in consideration of the added resources necessary for compliance.

We hope that the Division takes into consideration any health care legislation that may be passed in the remaining months of session, particularly the Senate President's bill relating to health insurance for individuals and small businesses. Any legislative changes that are adopted may have an affect on the proposed regulations.

We appreciate the opportunity to share our thoughts with you today and look forward to continuing to be a part of the dialogue. We would be happy to provide the Division with any assistance you may require as the specifications of the potential All Payers Claims Database are developed.

Please do not hesitate to contact me with any questions you may have. Thank you for your thoughtful consideration of these important issues.

Sincerely,

Michael Caljouw